(For State Use Only)

Pharmacies

State Pharmacy Board License Number*	DEA Registration Number*

*You must attach a copy of license. *You must attach a copy of Controlled Substance Registration Certificate

Name of Licensed, Registered Pharmacist (In full and actual charge of the Pharmacy)(print or type.)

Pharmacist's License Number*	Pharmacist's Signature	Date of Signature (mm/dd/yyyy)
		___/___/_____

*You must attach a copy of license.

Medical Suppliers

State Vendor's License Number*

*You must attach a copy of license.

or

State Tax Exemption Certificate Number*

*You must attach a copy of Certificate.

Are you dispensing hearing aids? ☐ YES ☐ NO If yes, please enter the appropriate License Number below.

Hearing Aid Dispensor License Number*

*You must attach a copy of license.

or

Audiologist License Number*

*You must attach a copy of license.

Physiological Laboratories

Physician's Certification: *I certify that* (check one):

☐ I own or partially own the laboratory facility and employ the operating personnel.

☐ I am a part-time employee or an employee under contract whose responsibilities include checking the procedural and quality control manuals, observing the operator's or technician's performance, verifying that the equipment and personnel meet applicable federal, state, and local licensure and registration requirements, and assuring that safe operating procedures and quality control procedures are used.

Physician's Name (print)	Physician's Signature	Date of Signature (mm/dd/yyyy)
		___/___/_____

Eligible Medicaid providers of Independent Physiological Laboratory services must meet the following criteria:

1. Possess a current unrevoked or unsuspended Medicare Provider Number as an independent physiological laboratory.
2. Be in conformity with all applicable federal, state, and local laws and regulations.
3. Provide nonradiological services under the general supervision of a physician who is certified or meets the requirements and/or training in the performance and interpretation of physiological laboratory procedures.
4. Provide radiological services under the following conditions:
   a) The services are performed under the general supervision of a licensed doctor of medicine or licensed doctor of osteopathy who is qualified by advanced training and experience in the use of x-rays as defined below:
      i) The physician is certified in radiology by the American Board of Radiology or by the American Osteopathy Board of Radiology or possesses qualifications which are equivalent to those required for such certification;
      ii) The physician is certified or meets the requirements for certification in a specialty in which the physician has become qualified by experience and/or training in the use of x-rays for diagnostic purposes.
   b) All operators of the x-ray equipment must meet the following requirements:
      i) Successful completion of a program of formal training in x-ray technology of not less than 24 months duration in a school approved by the Council on Education of the American Medical Association, or have earned a bachelor of science degree or associate degree in radiology technology from an accredited college or university.
      ii) For those whose training was completed prior to July 1, 1966, but on or after July 1, 1960, successful completion of 24 full months of training under the direct supervision of a physician who meets the definition of a qualified physician.
5. Radiology procedures are conducted in compliance with radiology safety standards which assure that the equipment and the operating procedures used minimize the radiation exposure and hazards for patients, personnel, and other persons in the immediate environment.

   X-ray equipment and shielding are inspected by qualified individuals at intervals not greater than every 24 months.

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(For State Use Only)

Transportation Services

Medicare Certification Number (Ambulance Provider Applicants)*	Are you publicly owned and operated? ☐ YES ☐ NO If no, enter your ***State Ambulance Board License Number**** here ______

**You must attach copies of all licenses.* *Ambulance/Ambulette applicants must complete the "Ambulance/Ambulette Personnel" section. Providers of Ambulette services must complete the "Requirements for Ambulette/ Wheelchair Vehicle Provider" section.*

Ambulance/Ambulette Personnel (This page may be copied, as necessary)

List the Name of each vehicle Personnel, His/Her Medical Certification (i.e., EMT, American Red Cross Basic/ Community First Aid) and Certification Period. Please, print or type all responses.

You must attach a Copy of EACH Individual's Certification Card.

Technician's Name	EMT Card #	American Red Cross Basic/ Community First Aid	EMT Expiration Date/ or /Completed Date of American Red Cross Basic/ Community First Aid Training (mm/dd/yyyy)
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____
	__________	☐ YES ☐ NO	__/__/____

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Requirements for Ambulette/Wheelchair Vehicle Provider

All ambulette/wheelchair vehicle providers must **CERTIFY THAT THEY** operate vehicles which meet the following standards:

Check appropriate block for each statement.

YES ☐ NO ☐ The vehicle is specifically designed to transport one or more patients sitting in wheelchairs and has fasteners to secure the wheelchair to the floor or side of the vehicle to prevent wheelchair movement. In addition, the vehicle is equipped with restraints to secure the patient in the wheelchair.

YES ☐ NO ☐ The vehicle is equipped with a stable access ramp or hydraulic lift

YES ☐ NO ☐ The vehicle has provisions for secure storage of removable equipment and passenger property in order to prevent projectile injuries to passengers and driver in the event of an accident.

YES ☐ NO ☐ Each vehicle is equipped with, at a minimum, a fire extinguisher and an emergency first-aid kit.

YES ☐ NO ☐ The qualifications of each driver comport with local, state, and federal laws and regulations.

YES ☐ NO ☐ Each driver has a current card issued as proof of successful completion of the "American Red Cross" (or equivalent) basic or community course in first aid. You must attach a copy of the current American Red Cross card for each driver.

Federally Qualified Health Centers

Check appropriate block, and you must attach a copy of the Confirmation letter:

☐ Section 329 of Public Health Service Act grants

☐ Section 330 of Public Health Service Act grants

☐ Section 340 of Public Health Service Act grants

☐ Health and Human Services Certification

TN No. 99-009 Approval Date

Attachment 4.16-I

(For State Use Only)

Disclosure and Ownership/Control Interest Statement

Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations in spaces provided. List any additional names and addresses on the proper section of the sheet provided.

1. A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organization, agency, or practice that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

☐ YES ☐ NO

Who was it? Give name.	When? Give date (mm/dd/yyyy)	SSN/EIN
	__/__/____ to __/__/____	
Who was it? Give name.	When? Give date (mm/dd/yyyy)	SSN/EIN
	__/__/____ to __/__/____	

1. B. Are there any directors, officers, agents, or managing employees of the institution, agency, organization, or practice who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

☐ YES ☐ NO

Who was it? Give name.	When? Give date (mm/dd/yyyy)	SSN/EIN
	__/__/____ to __/__/____	
Who was it? Give name.	When? Give date (mm/dd/yyyy)	SSN/EIN
	__/__/____ to __/__/____	

2. A. List names, addresses for individuals, or the Employer Identification Number (EIN) for organizations having direct or indirect ownership or a controlling interest in the entity or practice.

Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN

2. B. Type of Entity or Practice: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Unincorporated Associations ☐ Other (specify)_____

2. C. If the disclosing entity or practice is a corporation, list names, addresses of the Directors, and EIN's for corporations.

Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN

D. Have you ever been issued an Ohio Medicaid Provider Number?

☐ YES ☐ NO If, YES, you must list them in the boxes below.

Provider Number	Provider Number	Provider Number	Provider Number
			99-009

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2. E. Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership, or Members of the Board of Directors.) If yes, list names, addresses of individuals, and provider numbers. If under Title XIX, list vendor number.

☐ YES ☐ NO

Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number

3. A. Has there been a change in ownership or control within the last year? If yes, when? (mm/dd/yyyy)

☐ YES ☐ NO __ __ / __ __ / __ __ __ __

3. B. Do you anticipate any change in ownership or control within the year? If yes, when? (mm/dd/yyyy)

☐ YES ☐ NO __ __ / __ __ / __ __ __ __

4. Is this entity operated by a management company, or leased in whole or part by another organization? If yes, give date of change in operations.(mm/dd/yyyy)

☐ YES ☐ NO __ __ / __ __ / __ __ __ __

5. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?

☐ YES ☐ NO

6. Is this entity chain affiliated? (If yes, list name, address of Corporation, and EIN number.)

☐ YES ☐ NO

Name	Address	EIN

Hospitals, only:

7. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years?

☐ YES ☐ NO If yes, give year of change. _____ Current Beds _____ Prior Beds _____

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary, as appropriate.

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TN No. 96-11 EFFECTIVE DATE 7/1/99

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Disclosure statement: Additional Names, Addresses, and Numbers by section.

Section: 1. A.

Who was it? Give name.	When? Give date (mm/dd/yyyy) __/__/____ to __/__/____	SSN/EIN
Who was it? Give name.	When? Give date (mm/dd/yyyy) __/__/____ to __/__/____	SSN/EIN
Who was it? Give name.	When? Give date (mm/dd/yyyy) __/__/____ to __/__/____	SSN/EIN

Section: 1. B.

Who was it? Give name.	When? Give date (mm/dd/yyyy) __/__/____ to __/__/____	SSN/EIN
Who was it? Give name.	When? Give date (mm/dd/yyyy) __/__/____ to __/__/____	SSN/EIN
Who was it? Give name.	When? Give date (mm/dd/yyyy) __/__/____ to __/__/____	SSN/EIN

Section: 2. A.

Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN

Section: 2. C.

Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
	Address	SSN/EIN
Name	Address	SSN/EIN

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Have you remembered...

..to complete, sign, date, and attach your Form **W-9**,

..to <u>double check</u> the **Application/Agreement** to make sure all applicable information has been included,

..to look for footnotes (*) on the Application/Agreement and attach the necessary material,

..to provide us with **<u>ALL</u>** names, addresses, and legal numbers as required,

..to complete **<u>ALL</u>** date fields,

..to sign and date the Application/Agreement at the bottom of page 11.

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SUPERSEDES 98-11 7/1/99

Attachment 4.16-I

For State Use Only

OHIO MEDICAID PROVIDER AGREEMENT

(For all providers except Long-Term Care Facilities)

This provider agreement is a contract between the Ohio Department of Human Services (the Department) and the undersigned provider of medical assistance services in which the Provider agrees to comply with the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifies to:

1. Render medical assistance services as medically necessary for the patient and only in the amount required by the patient without regard to race, creed, color, age, sex, national origin, source(s) of payment, or handicap, submit claims only for services actually performed, and bill the Department for no more than the usual and customary fee charged other patients for the same service;

2. Ascertain and recoup any third-party resource(s) available to the recipient prior to billing the Department. The Department will then pay any unpaid balance up to the lesser of the provider's billed charge or the maximum allowable reimbursement as set forth in Chapter 5101:3 of the Administrative Code.

3. Accept the allowable reimbursement for all covered services as payment-in-full and, except as required in paragraph 2 above, will not seek reimbursement for that service from the patient, any member of the family, or any other person.

4. Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed.

5. Furnish to the Department, the secretary of the Department of Health and Human Services, or the Ohio Medicaid fraud control unit or their designees any information maintained under paragraph 4 above for audit or review purposes. Audits may use statistical sampling. Failure to supply requested records within thirty days shall result in withholding of Medicaid or Disability Assistance Medical payments and may result in termination from the Medicaid and Disability Assistance Medical programs.

6. Inform the Department within thirty days of any changes in licensure, certification, or registration status; ownership; specialty; additions, deletions, or replacements in group membership and hospital-based physicians; and address;

sclose ownership and control information, and disclose the identity of any person (as specified in 42 CFR, Parts 455, Subpart B and 1002, Subpart , as amended, and as specified in rule 5101:3-1-173 of the Administrative Code) who has been convicted of a criminal offense related to Medicare, Medicaid, Disability Assistance Medical or Title XX services.

8. Neither the individual practitioner, nor the company, nor any owner, director, officer, employee of the company, or any independent contractor retained by the company or any of the aforementioned persons, currently is subject to sanction under Medicare, Medicaid, Disability Assistance Medical or Title XX or otherwise is prohibited from providing services to Medicare, Medicaid, Disability Assistance Medical or Title XX beneficiaries.

9. To follow the regulations and policies set forth in the appropriate edition of the Medicaid Handbook.

10. Provide to ODHS, through the court of jurisdiction, notice of any action brought by the provider in accordance with the Title 11 of the United States Code (Bankruptcy). Notice shall be mailed to: "Office of Legal Services, Ohio Department of Human Servies, 30 East Broad Street - 31st Floor, Columbus, Ohio 43215".

1. Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR 489, Subpart I and 42 CFR 417.436(d).

is provider agreement may be canceled by either party upon 30 days written notice prior to termination date except in the case of health maintenance organizations (HMOs) who must notify the Department in writing least 90 days prior to the date of cancellation.

---

further certify that I am the individual practitioner who is applying for the provider number, or in the case of a business ganization, I am the officer, chief executive officer, or general partner of the business organization that is applying for the provider mber. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.

r Individual practitioners:

lividual Practitioner Name and Title (*please print*) :_____

ividual Practitioner Signature:_____ Date: __/__/__ (mm/dd/yyyy)

for groups or organizations:

horized Representative Name and Title (*please print*) :_____

' Representative Signature:_____ Date: 10/1/99 (mm/dd/yyyy)

ATTACH ALL COPIES OF LICENSURE, CERTIFICATION, REGISTRATION, ETC., AS REQUIRED FOR YOUR PROVIDER TYPE

PPLICATIONS SUBMITTED WITHOUT THE REQUIRED ATTACHMENTS WILL BE CONSIDERED INCOMPLETE AND RETURNED TO THE APPLICANT

SUPERSEDES

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TN No. 98-11

EFFECTIVE DATE 7/1/99

ature of Authorized Agent:_____ ***Date:***__/__/__ (mm/dd/yyyy)

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Date Received(1)	Date Received(2)	Date Received(3)	Date Received(4)
Date Returned(1)	Date Returned(2)	Date Returned(3)	Date Returned(4)

Date Processed	Effective Date	Provider Number
Operator's Number	Application Number: 3620	Ticket Number

This Form May NOT Be Duplicated

TR No. 99-09 APPROVAL DATE

SUPERSEDES

98-11

11/1/1

Attachment 4.16-I

George V. Voinovich
Governor

Arnold R. Tompkins
Director

Ohio Department of Human Services

PROVIDER RELATIONS SECTION
P.O. Box 1461, Columbus, Ohio 43266-0161
950-5627 then dial (8-3288)

Dear Provider of Medical Services:

This form is an application/agreement for enrollment in the Ohio Medicaid program as a medical group. A group provider, for Medicaid enrollment , must be an organization composed solely of two or more individuals of the same profession who are members of a professional association organized under Chapter 1785, of the Revised Code, each of whom is licensed or approved by a standard-setting or regulatory agency to render the same kind of professional service and approved participation in the Medicaid program by the Ohio Department of Human Services as an individual provider. Multiple location **group** providers must complete a separate Form 6752 for **each** location. A group must have a provider agreement signed by an authorized agent of that group to be an active Ohio Medicaid provider. Medicaid reimbursement is contingent upon a valid provider agreement being in effect while the services were provided.

Each section of the application contains specific instructions for completion and may require you to attach specific information. Read each section carefully as instructions and requirements may vary for different types of groups. If there are blocks on the application that are not applicable to your group, then leave those particular areas blank. **However, incomplete applications or completed applications without required attachments will be returned to you for correction.** Upon completion of the application, an authorized agent of the group is to read, sign, and date the provider agreement portion of this form. Should this area be left unsigned or undated your application for enrollment will be considered incomplete and will be returned to you for completion. Properly completed applications will be processed and you will be notified by mail of your Medicaid provider status.

The department may deny a provider application/agreement for reasons including, but not limited to:

*Any license, permit, or certificate that is required by the department has been denied, suspended, revoked or not renewed.

*The provider is terminated, suspended or excluded by the Medicare program and/or by the federal Department of Health and Human Services and that action is binding on the provider's participation in the Medicaid program or renders federal financial participation unavailable for the provider's participation in the Medicaid program.

*The organization's owner, officer, authorized agent, associate, manager, or employee has pled guilty to, or been convicted of a criminal activity materially related to either the Medicare or Medicaid program.

*A judgement has been entered in either a criminal or civil action against a Medicaid provider or it's owner, officer, authorized agent, associate, manager, or employee in an action brought pursuant to Section 109.85 of the Revised Code.

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